Pattern of hospital referrals of children at risk of maltreatment

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ABSTRACT

Background Increasingly emergency departments (ED) and other acute services in the hospital provide first access care, especially out of hours and for poorer families. Studies of detection of child maltreatment in the hospital have focused on children presenting with injury, although maltreatment may be suspected when parents present to the hospital with problems related to violent behaviour, drug abuse or mental health problems.

Methods A consecutive case series is described of patients referred for suspected child maltreatment from one inner-city general hospital after training was given to clinical staff and 2 years after the creation of a new post comprising a full-time, experienced child protection advisor (CPA) on-site to support clinicians with concerns about child maltreatment.

Results There were 44 referrals to the CPA over 2 months in 2005, of whom just under half were initiated by clinicians caring for a parent. 15 referrals came from the ED (five followed a parent presenting to the ED), 14 from maternity obstetric services, and 15 from the neonatal or paediatric wards. Most families (38; 86%) were referred by nurses. One-quarter of referrals were already known to children's social care.

Conclusions Clinicians need to be aware that half the vulnerable children in hospital are identified through one or other parent. It is hypothesised that the availability of an experienced child protection advisor on-site, combined with child protection training, makes it possible for clinicians caring for adults with problems related to violence, drug abuse or acute mental illness, to take action to address the potential vulnerability of their children.

INTRODUCTION

Few maltreated children attend hospital with injuries due to their maltreatment.[1] Therefore, healthcare professionals need to be aware of the signs and symptoms of maltreatment in non-injured children or if their parents present to hospital. When dealing with parents as patients, clinicians need to be alert to the possibility of child maltreatment and to ask questions about the children's care. Despite the claim that 'child protection is everyone's responsibility',[2] guidelines focus almost entirely on recognition and response to child maltreatment by health professionals working with children. A recent review found very few published studies that evaluated recognition of child maltreatment through parents presenting to healthcare services,[1] and a recent 2009 Care Quality Commission report found that 37% of NHS Trusts had no policy for ensuring that adults are routinely asked about dependents or caring responsibility.[3]

Following the Laming Enquiry in 2003,[2] which emphasised the importance of detecting children presenting to hospitals with maltreatment or at risk of maltreatment, an inner London teaching hospital created a new post of child protection advisor (CPA). The person appointed had a social work background. She developed an extensive training programme for all hospital staff in acute services about the signs of child maltreatment, established an advisory support service so that clinicians could refer children who they were concerned about to her and set out new guidelines for subsequent action. In cases where there was a lack of clarity she provided a forum for discussion. She worked closely, and in parallel, with the established hospital social care team.

After the CP advisory service had been in place for 2 years, an audit was conducted. This aimed to determine the number and sources of referrals to the CPA, and also whether the service had impacted on acute adult care, which, traditionally, rarely reported children for child protection.

METHOD

The study took place in an inner London teaching hospital with a dedicated social care department. The hospital emergency department (ED) is attended by approximately 16 600 children each year and 66 500 adults. Maternity services for 3138 deliveries per year, a 17-cot neonatal intensive care unit, an 18-bed acute paediatric unit and a 17-bed adolescent unit are on the same site.

When a clinician had a concern about possible child maltreatment they could refer the case to the CPA, the hospital or borough social worker. All of these referrals were recorded on a standardised referral form and copied to the CPA, so that she could help to coordinate the case or respond directly herself. These standardised referral forms were used to audit consecutive referrals for possible child maltreatment over a 2-month period, August–October 2005. Data extracted from the referral forms for the audit concerned the clinical reason for referral, the professional who initiated the referral and whether the child (or family) was known to social care. The data were grouped according to whether the child or parent presented. The reasons for referral were divided into four categories, across both these groups: violence, acute mental health, drug and alcohol misuse, and social concerns, ie childcare, supervision and housing.

RESULTS

A total of 44 children under the age of 18 or pregnant women were referred during the 2-month

Table 1 Source of referrals for possible child maltreatment according to whether the patient presenting for care was the parent or the child (n (%))

	Parent 19 (43)	Child 25 (57)	Total 44 (100)	Known to social care 11 (25)
Source of referral				
Emergency department (ED)	5	10	15 (34)	6
Nurse	4	8	12 (27)	
Doctor	1	0	1 (2)	
Liaison health visitor	0	2	2 (5)	
Antenatal/neonatal (AN)	14	1	15 (34)	
Nurse/midwife	14	1	15 (34)	
Doctor	0	0	0 (0)	
Paediatric ward	0	14	14 (32)	5
Nurse	0	11	11 (25)	
Doctor	0	2	2 (5)	
Liaison health visitor	0	1	1 (2)	
Clinical reason for referral*				
Exposure to violence	3 (AN)	10	13 (29)	
Acute mental health problem	2 (1 ED, 1 AN)	2	4 (9)	
Drug/alcohol abuse	11 (3 ED, 8 AN)	6	17 (39)	
Care/supervision/housing problem	3 (1 ED, 2 AN)	7	10 (23)	

*Not exclusive categories.

audit. (table 1) Referrals were initiated in four hospital departments: 15 (34%) in the ED, of which 10 cases (23%) resulted from children's attendances and five (11%) from parents presenting to the ED. Fourteen (32%) referrals were initiated for pregnant women during antenatal care, and one baby (2%) was referred from the neonatal unit. The remaining 14 (32%) referrals were made for children who were inpatients on the paediatric or adolescent wards.

Nurses made the majority (38/44; 86%) of the referrals. The remainder were made by the liaison health visitor (3/44; 7%) or doctors (3/44; 7%; table 1).

Table 1 shows the reasons for referral in the 25 (57%) children and adolescents presenting to hospital and 19 (43%) parents. In the group of 10 children referred for exposure to violence, only one was referred for possible physical abuse by his primary caregiver (2% of the 44 referrals), but four other children were referred for violence between peers, two for bullying by peers and three for exposure to domestic violence. The other clinical reasons for referring from the child's presentation comprised acute mental health problems in two, drug and alcohol abuse in six, and concerns about the adequacy of childcare, supervision and housing in seven.

The five parents referred from ED were for drug overdose (two) alcoholic seizure (one), psychosis (one) and children home alone (one). The parent with psychosis was already known to social care. All the other parental referrals (14) stemmed from antenatal concerns and crossed all four categories.

Overall, 11 (25%) of the 44 families were already known to social care.

In addition, it is known from the hospital Annual Report that there was a 29% increase in referrals to social care including concerns in the parent's presentation, after the appointment of the CPA.[4]

DISCUSSION

Nearly half (43%) of the children at risk of maltreatment were identified because of concerns about parental behaviour. The reasons why parental behaviour led to referral of a child included exposure to violence within the home and community setting, acute mental illness, drug and alcohol abuse, and care/supervision and housing issues.

One limitation of the study was the small sample size and absence of comparable data before the appointment of a CPA. Despite the small number of cases, the finding that half of the cases of possible maltreatment were recognised through their parents as patients was striking. Asking about children is usually included in current training guidelines for all working in health settings.[5] However, evidence on the relative importance of identifying maltreatment through parents as patients has not been quantified. There is also a lack of research and guidance about how clinicians should approach parents, who themselves may be acutely ill and vulnerable, and who need to feel supported by healthcare services and not threatened by child protection proceedings. This difficult combination of child advocacy, although providing healthcare and support to the parent, needs further research.

Studies[6–8] show that reporting of suspicions of child maltreatment is low because of the lack of confidence in social care organisation, along with anxiety about complaints reflected in the research published by the Royal College of Paediatrics and Child Health.[9] In spite of this, the hospital Annual Report[4] documented a 29% increase in referrals to social care after appointment of the CPA. In addition, of the 44 referrals only one child was referred who may have been physically abused, signifying the need for clinicians to be aware of the diversity of presentations of child maltreatment. It is suggested here that access to a dedicated full-time CPA for support and advice, combined with her active role in awareness raising and training in the 2 years prior to the study, appears to uncover a previously unmet need and instils in staff the confidence to freely report all concerns. The only evidence we found on the effectiveness of a skilled coordinating professional within hospitals was by Bajaj *et al*, who showed that the coordinator had a role in raising awareness, improving documentation and in the follow-up of child welfare concerns.[10]

It was found that nurses, both in the ED and on the ward, were the main source of referral to the CPA, despite their lack of confidence in diagnosing child abuse and their reluctance to

refer.[11 12] The CP advisory service offers a lower threshold for referral, perhaps helping the nurses to make a judgement without obtaining the authority of a doctor. It may be that the perceived harms of talking to the CPA are much less than to social care, and as a result nurses feel able to do this more readily.

One-quarter of the children referred were already known to social care services. The opportunity for identification in a hospital setting should not be missed as it allows the abused child to be protected if this additional factor raises the threshold for significant harm. The referral enhances the liaison between the hospital and social care and contributes to the picture of the child's needs as described in the Common Assessment Framework (CAF).[13] As child maltreatment is a cumulative and chronic condition,[14] referral of any suspicion is vital in identifying the need for appropriate support.

This small study has shown that, as a proportion of all referrals to social care from a hospital setting, nearly half the referrals come from identifying vulnerable children through their parents. It is important to take action for children at times of parental distress and illness. Doctors and nurses have an important role to play in timely and appropriate referrals.

CONCLUSIONS

In every hospital, opportunities for identifying and referring children that are potentially at risk should not be missed. Despite the small sample size of this study, the findings illustrate the potential for identification of vulnerable children through their parents and the variety of presentations of child maltreatment in different hospital settings. Although comparable data are lacking prior to the appointment of the CPA, the results point to the value of this service and its contribution to safeguarding.

Training all hospital staff to be aware of the warning signs and symptoms of child maltreatment, not only in children but also in parents who may present to adult services, is recommended. Directions for future research include guidance on how to approach vulnerable adults, who attend hospital in need of healthcare and support for themselves, with regard to their children. It is also recognised that more research is needed on how to involve adult services at children and young peoples' multiagency meetings such as the child protection conferences. To quote Lord Laming, 'child protection is everyone's responsibility'.[2]

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Notes